



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARCUS HAYES DC
P O BOX 198
BARKER TX 77413-0198

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-1253-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I submitted an incorrect CPT code for the MMI/IR evaluation on said claimant on said date in the amount of \$650.00. Instead of denying payment of the claim due to this improper coding, the IC reimbursed me \$274.19 for the incorrectly coded claim. On 09/16/2010, I submitted a request for reconsideration (RFR) that included the correct CPT code and requested the balance due of \$375.81. In response to the RFR submitted, the IC reimbursed me an additional \$75.81 and reduced the balance by \$300.00. That brought the total reimbursed to \$350.00. On 10/16/2010, I submitted another RFR stating that the total reimbursement of \$350.00 was for the MMI assessment and the \$300.00 reduction was incorrect as the \$300.00 was the fee for IR calculation. The IC did not respond to the 10/16/2010 RFR in a timely manner, so on 11/13/2010, I submitted a 'No Response' letter to the IC. The IC still has not responded to the RFR for the additional \$300.00 for IR assessment. In summary, the IC only reimbursed AI&FATC for MMI assessment (\$350) and *not* for IR calculation (\$300). Two requests for payment were made regarding the \$300 balance, however, the IC has not responded to either request."

Amount in Dispute: \$300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response for consideration to this dispute.

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| August 31, 2010 | CPT Code 99456-WP | \$300.00 | \$300.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. 28 Texas Administrative Code §130.1 sets out the guidelines for Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 9, 2010

- 1 – (45) – Charges exceed your contracted/legislated fee arrangement.
- 2 – (W1) – Workers Compensation State Fee Schedule Adjustment

Explanation of benefits dated October 11, 2010

- 1 – (45) – Charges exceed your contracted/legislated fee arrangement.
- 2 – (W1) – Workers Compensation State Fee Schedule Adjustment

Issues

1. Is the respondent's claim adjustment reason code "45" supported?
2. Has the Designated Doctor (DD) examination been reimbursed appropriated per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. According to the explanation of benefits dated September 9, 2010 and October 11, 2010, the carrier reduced the medical bill based on "45– Charges exceed your contracted/legislated fee arrangement." A signed acknowledgement indicates that the respondent, New Hampshire Insurance Company was notified of the fee dispute on December 31, 2010. New Hampshire Insurance Company did not respond to the requestor's dispute. Because the respondent did not clarify or otherwise address the 45 claim adjustment code upon receipt of the request for dispute resolution, the Division finds that the 45 claim adjustment code is not supported. For that reason, the dispute will be reviewed in accordance with 28 Texas Administrative Code §134.204.
2. The requestor billed the amount of \$650.00 for CPT code 99456-WP with 1 (one) unit in Box 24G of the CMS-1500 for a Designated Doctor examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the submitted documentation supports that Maximum Medical Improvement (MMI) was assigned. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is \$350.00. Review of the submitted documentation supports the impairment rating of the left elbow (upper extremity) with the Range of Motion (ROM) Impairment Rating method per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a). The Impairment Rating per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the upper extremity is per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) and the Maximum Allowable Reimbursement (MAR) for the Impairment Rating is \$300.00. The Maximum Allowable Reimbursement (MAR) for the disputed CPT code 99456-WP is \$650.00. The combined MAR for the MMI/IR examinations is \$650.00.
3. The respondent previously reimbursed the requestor the amount of \$350.00 on CPT code 99456-WP. The requestor is due a recommended additional reimbursement in the amount of \$300.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$300.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

| | | |
|-----------|--|----------------|
| _____ | _____ | April 13, 2012 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.